TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1 DALLAS

Respondent Name
CHUBB INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-17-0561-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 31, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provide and the claims were denied per EOB based on entitlement to benefits... The treatment that was provided is part of his compensable injury..."

Amount in Dispute: $14,945.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is an outstanding extent of injury issue involved on Claimant's [date of injury] date of injury with regards to the treatment provided by Requestor in this matter... Requestor has treated more than the accepted body parts... The medical documentation on these dates of service show that they were not treating the claimant for the compensable injury despite the diagnosis codes that were put on the medical bill."

Response Submitted by: Downs Stanford PC

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 24, 2015 through February 4, 2016	97799-CP-CA and 96151	$14,945.66	$1,507.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §141.1 sets out the procedures for Requesting and Setting a Benefit Review Conference.
4. 28 Administrative Code § 133.240 sets out the medical bill processing/audit by an insurance carrier for medical payments and denials.
5. Former Texas Labor Code §408.027 sets out the payment of health care provider.
6. 28 Texas Administrative Code §134.204 sets out the sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
7. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P6-Based on entitlement to benefits
   - 219-Based on extent of injury
   - P12 – Workers' Compensation state fee schedule adjustment

Issue(s)

1. Does the medical fee dispute referenced above contain information/documentation to support that the disputed services contain an unresolved relatedness issue?
2. Does the insurance carrier's position statement address only those denial reasons presented to the requestor for dates of service, January 4, 2016, January 6, 2016 and February 4, 2016, prior to the date the request for MFDR was filed?
3. Is the requestor entitled to reimbursement for CPT Code 96151 rendered on February 4, 2016?
4. Is the requestor entitled to reimbursement for CPT Code 97799-CP-CA rendered on January 4, 2016 and January 6, 2016?

Findings

1. The insurance carrier denied CPT Code(s) 97799-CP-CA rendered on November 24, 2015 through December 31, 2015, January 5, 2016, January 7, 2016, January 8, 2016, January 11, 2016 and January 14, 2016, with denial reason(s) code "P6-Based on entitlement to benefits." and "219-Based on extent of injury.

   Review of the submitted documentation finds that the medical fee dispute referenced above contains information/ documentation to support that there are **unresolved** issues of relatedness/extent of injury for dates of service November 24, 2015 through December 31, 2015, January 5, 2016, January 7, 2016, January 8, 2016, January 11, 2016 and January 14, 2016. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that a relatedness/extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved relatedness/ extent-of-injury issue. The Division finds that the dispute contains an unresolved relatedness/extent-of-injury issue for the dates of service indicated above. As a result, the dates of service identified above are not eligible for review by MFDR until final adjudication of the relatedness/extent-of-injury issue.

   The Division hereby notifies the requestor that the appropriate process to resolve the relatedness/extent-of-injury issue may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

2. The requestor seeks reimbursement for CPT Codes 97799-CP-CA rendered on January 4, 2016, January 6, 2016, and CPT Code 96151 rendered on February 4, 2016. The insurance carrier's position statement asserts that "There is an outstanding extent of injury issue involved on Claimant's [date of injury] date of injury with regards to the treatment provided by Requestor in this matter." Review of the EOBs presented by the insurance carrier and the requestor finds the following:

   CPT Code 97799 rendered on January 4, 2016, January 6, 2016, and CPT Code 96151 rendered on February 4, 2016

   EOB dated February 23, 2016 contains the following denial reason code(s):

   - P12 – Workers' Compensation state fee schedule adjustment

   EOB dated March 17, 2016 contains the following denial reason code(s):

   - P12 – Workers' Compensation state fee schedule adjustment

   To determine whether such an extent-of-injury or relatedness dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code § 133.240 (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service(s) was/were not related to the compensable injury:

Per 31 TexReg 3544, 3558 (April 28, 2006), those provisions, in pertinent part specified: Former 133.240 (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee."

No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment. The EOB indicates that "Workers Compensation state fee schedule adjustment," however no payment was issued for the disputed codes. The Division concludes that the respondent has not met the requirements of 408.027. This new defenses are therefore not supported for CPT Codes 97799-CP-CA rendered on January 4, 2016, January 6, 2016, and CPT Code 96151 rendered on February 4, 2016**.** The disputed service(s) are therefore reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 96151, rendered on February 4, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.48 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.48864. The practice expense (PE) RVU of 0.08 multiplied by the PE GPCI of 1.009 is 0.08072. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.5848 is multiplied by the Division conversion factor of $56.82 for a MAR of $33.23 at 4 units is $132.92. Therefore this amount is recommended.

5. 28 Texas Administrative Code §134.204 (h) states, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier."

   28 Texas Administrative Code §134.204 (h) (5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   The requestor submitted copies of CMS-1500, which documents the billing of CPT Code 97799-CP and modifier CA, which identifies the chronic pain management program as CARF accredited. As a result, reimbursement is calculated at $125 per hour. Review of the submitted documentation for dates of service January 4, 2016 and January 6, 2016 finds the following:

Date of service: January 4, 2016, the requestor documented and billed 4 hours. The MAR reimbursement is $125/hour x 4 hours = $500.00, therefore, this amount is recommended.

Date of service: January 6, 2016, the requestor documented and billed 7 hours. The MAR reimbursement is $125/hour x 7 hours = $875.00, therefore, this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $1,507.92. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,507.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,507.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 2, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.